The Challenge of Medical Errors

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TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM

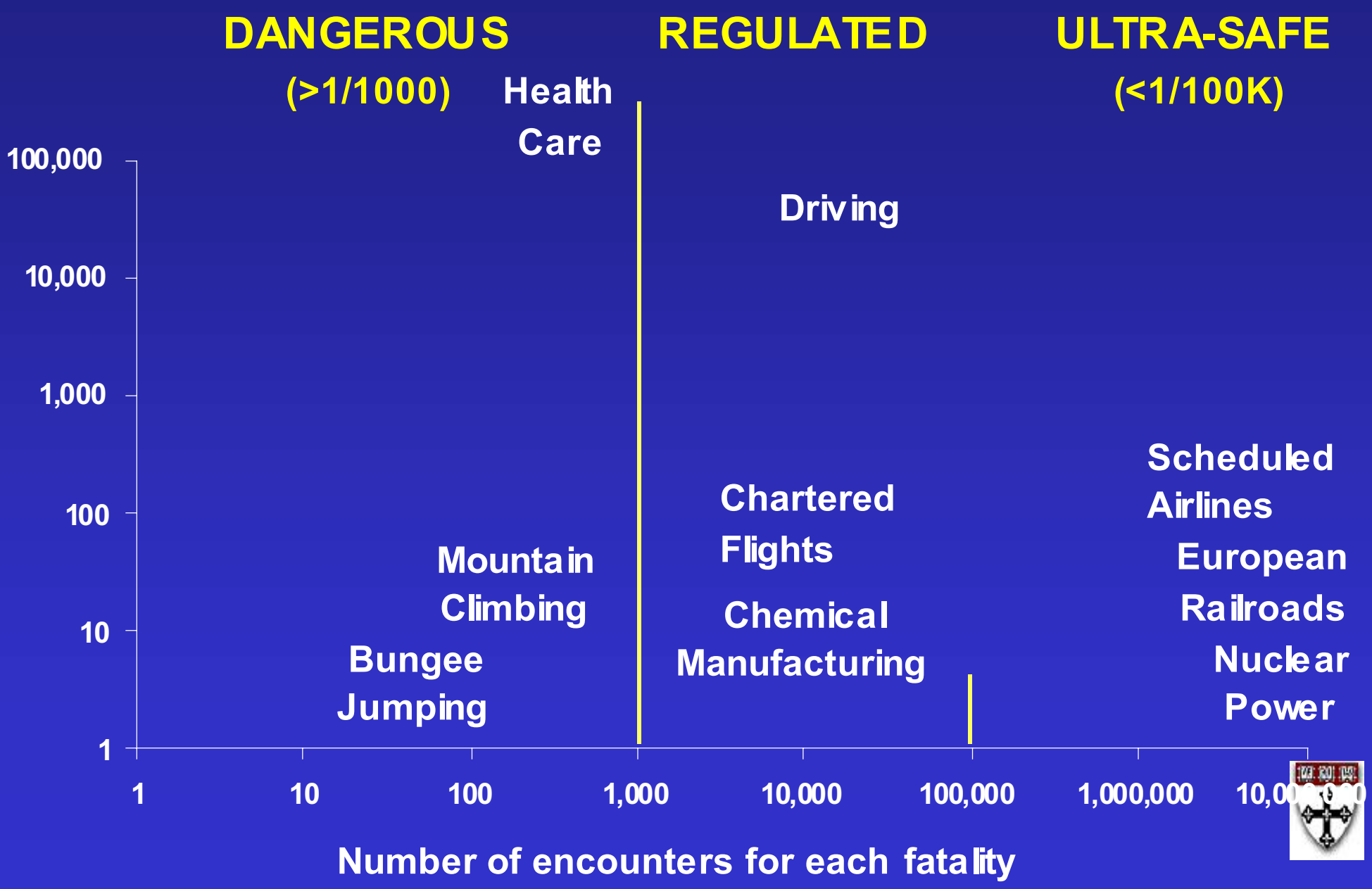
Institute of Medicine

Committee on Quality of Health Care in America

IOM Findings

- Medical errors are a serious problem
- The cause is bad systems
- We need to redesign our systems
- We need to make safety a national priority

How Hazardous Is Health Care?



IOM Findings

- Medical errors are a serious problem
- The cause is bad systems

The idea that medical errors are caused by bad systems is a transforming concept

The Perfection Myth

If we try hard enough we will not make any errors

The Punishment Myth

If we punish people when they make errors they will make fewer of them

- Everyone makes errors everyday
- No one makes an error on purpose
- An error is not misconduct
- We make errors for reasons

Causes of Errors

Habit	Anger
Interruptions	Anxiety
Hurry	Boredom
Fatigue	Fear

To err is human,

To forgive, divine

Alexander Pope

Lessons from Human Factors Research

Many errors are caused by activities that rely on weak aspects of cognition

E.g., - Short-term memory
- Attention

Lessons from Human Factors Research

Errors can be prevented by designing tasks and processes
to minimize dependency on weak cognitive functions

Human Factors Principles

- Avoid reliance on memory
- Simplify
- Standardize
- Use constraints and forcing functions
- Use protocols & checklists wisely
- Avoid fatigue

Human Factors Violations - 1

- Reliance on memory
- Excessive number of handoffs
- Non-standard processes
- Resist use of protocols

Human Factors Violations - 2

- Long work hours
- Excessive work loads
- Spotty feedback
- Variable information availability

Types of Systems

- Process, tasks, and equipment
- Education and training
- Conditions of work
- Management and teamwork
- Organizational culture

The Blaming Culture

- Affects everyone - we do it to ourselves and to each other
- Singularly ineffective at preventing errors and injuries
- Focus on individual diverts attention away from systems
- Strong incentive to dishonesty and cover-up

From Blaming to Responsibility

- Doctors and Nurses
- Hospitals and Health Care Organizations
- Regulators

Doctors and Nurses

- Practice safely
  - Follow best practices
  - Identify unsafe systems
  - Help change systems
- Be honest with patients
- Take responsibility for problem doctors

Hospitals and HCOs

Because safety is primarily a systems characteristic, then the primary responsibility for safety rests with the party in charge of the systems: the hospital, nursing home or other HCO.

Tri-level Changes for Safety

- **Change the culture**
- **Implement known "best practices"**
  - "Quick fixes"
  - Expensive fixes
- **Change systems**
  - Specific - medication system
  - General - hours, staffing, work loads

Five Things a HCO Can Do Now to Improve Safety

1 -- Make safety part of your strategic plan

2 – Stop punishing people for making errors

3 – Implement recommended safe medication practices

4 – Begin multiple hunts for hazards

5 -- Plan to implement CPOE, EMR

Ensuring Competence

- Everyone has avoided it:
  - Hospital boards
  - Management
  - Physicians
- Highest responsibility of a profession

A "Problem Doctor" System

- Proactive - *before* patient harm
- Goal: continue in practice
- Criteria-based: must develop performance measures
- Fair - everyone is monitored

Responsive Regulation

- Move out of the reactive mode
  - Perpetuates blaming mentality
  - Keeps focus on individual, not system
- Take responsibility for safe practices

Responsive Regulation

- Remove barriers to safety
  - Stop punishing for errors
  - Protect against disclosure
- Set standards for safety
- Enforce them

Set Safety Standards

- Require safety programs in HCO
- Require basic medication safety practices be implemented
- Set maximum hours for house officers
- Prohibit double shifts for nurses
- Establish Staffing ratios
- Require MD in ERs

Accountability